FOR BHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042119

Facility Name: South Shore Nsg & Rehab Center

Address: 2649 East 75th Street (Number) Chicago (City) 60649 (Zip Code)

County: Cook

Telephone Number: (773) 356-9300 **Fax #** (773) 356-9384

HFS ID Number: 364209295001

Date of Initial License for Current Owners: 05/28/98

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Edward N. Slack, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 Report Period Beginning: 01/01/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	240	Skilled (SNF)	240	87,600	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	240	TOTALS	240	87,600	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	60,327	4,703	11,695	76,725	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	60,327	4,703	11,695	76,725	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.59%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/28/98

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/2/8/98 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 240 and days of care provided 9,962

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/05 Fiscal Year: 12/31/05

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	366,278	49,608	24,145	440,031		440,031	1,413	441,444			1
2	Food Purchase		328,721		328,721	(8,935)	319,786	8,399	328,185			2
3	Housekeeping	239,058	60,728	880	300,666		300,666	(5,906)	294,760			3
4	Laundry	125,523	31,098		156,621		156,621	(147)	156,474			4
5	Heat and Other Utilities			338,592	338,592		338,592	3,033	341,625			5
6	Maintenance	84,859		261,801	346,660		346,660	22,662	369,322			6
7	Other (specify):*							5,263	5,263			7
8	TOTAL General Services	815,718	470,155	625,418	1,911,291	(8,935)	1,902,356	34,718	1,937,074			8
	B. Health Care and Programs											
9	Medical Director			27,000	27,000		27,000		27,000			9
10	Nursing and Medical Records	2,955,437	68,681	154,679	3,178,797		3,178,797	(4,327)	3,174,470			10
10a	Therapy	115,771		567	116,338		116,338	633	116,971			10a
11	Activities	177,824	5,738	2,536	186,098		186,098		186,098			11
12	Social Services	197,817		1,352	199,169		199,169		199,169			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							2,360	2,360			15
16	TOTAL Health Care and Programs	3,446,849	74,419	186,134	3,707,402		3,707,402	(1,334)	3,706,068			16
	C. General Administration											
17	Administrative	94,721		36,000	130,721		130,721	45,771	176,492			17
18	Directors Fees											18
19	Professional Services			402,382	402,382		402,382	(298,074)	104,308			19
20	Dues, Fees, Subscriptions & Promotions			100,778	100,778		100,778	(27,512)	73,266			20
21	Clerical & General Office Expenses	87,237	28,257	1,555,954	1,671,448		1,671,448	(1,272,386)	399,062			21
22	Employee Benefits & Payroll Taxes			701,628	701,628	8,935	710,563	(4,041)	706,522			22
23	Inservice Training & Education			1,536	1,536		1,536		1,536			23
24	Travel and Seminar			708	708		708	6,864	7,572			24
25	Other Admin. Staff Transportation			1,205	1,205		1,205		1,205			25
26	Insurance-Prop.Liab.Malpractice			267,002	267,002		267,002	2,739	269,741			26
27	Other (specify):*							37,237	37,237			27
28	TOTAL General Administration	181,958	28,257	3,067,193	3,277,408	8,935	3,286,343	(1,509,402)	1,776,941			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,444,525	572,831	3,878,745	8,896,101		8,896,101	(1,476,018)	7,420,083			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number South Shore Nsg & Rehab Center #0042119 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			61,307	61,307		61,307	371,873	433,180			30
31	Amortization of Pre-Op. & Org.			4,380	4,380		4,380		4,380			31
32	Interest							340,954	340,954			32
33	Real Estate Taxes			344,350	344,350		344,350	2,494	346,844			33
34	Rent-Facility & Grounds			1,357,800	1,357,800		1,357,800	(1,345,989)	11,811			34
35	Rent-Equipment & Vehicles			8,890	8,890		8,890	2,176	11,066			35
36	Other (specify):*							80,928	80,928			36
37	**TOTAL Ownership**			1,776,727	1,776,727		1,776,727	(547,564)	1,229,163			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		499,521	780,853	1,280,374		1,280,374	(29,958)	1,250,416			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			131,400	131,400		131,400		131,400			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		499,521	912,253	1,411,774		1,411,774	(29,958)	1,381,816			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,444,525	1,072,352	6,567,725	12,084,602		12,084,602	(2,053,540)	10,031,062			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 Report Period Beginning: 01/01/05 Ending: 12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	49,615	30		9
10	Interest and Other Investment Income	(560,176)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(198)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(20,943)	21		18
19	Entertainment				19
20	Contributions	(1,000)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,305,441)	21		24
25	Fund Raising, Advertising and Promotional	(32,950)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(100)	20		28
29	Other-Attach Schedule	(188,163)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (2,059,356)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	5,815		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 5,815		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (2,053,540)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 5A

South Shore Nsg & Rehab Center

ID# 0042119

Report Period Beginning: 01/01/05

Ending: 12/31/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Theft Loss	$ (100)	21	1
2	Illinois Replacement Tax	(2,102)	21	2
3	Patient Clothing	(132)	10	3
4	Collection Expense	(532)	21	4
5	Jury Duty	(52)	10	5
6	Building Company - Filing Fees	(250)	20	6
7	Building Company - Trust Fees	(320)	20	7
8	Miscellaneous Income	(274)	21	8
9				9
10	Prior Year Legal	(4,321)	19	10
11	Non Allowable Expense	(180,000)	21	11
12				12
13				13
14				14
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100				100
101	Total	(188,163)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary				(9)	482		5,497	(4,557)				1,413	1
2	Food Purchase	(198)							8,597				8,399	2
3	Housekeeping				(5,906)								(5,906)	3
4	Laundry				(147)								(147)	4
5	Heat and Other Utilities					3,033							3,033	5
6	Maintenance				(77)	7,413	8,548	6,686	92				22,662	6
7	Other (specify):*						2,122	1,750	1,391				5,263	7
8	**TOTAL General Services**	(198)			(6,139)	10,928	10,670	13,933	5,523				34,718	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(184)			(4,143)								(4,327)	10
10a	Therapy						(92)	725					633	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*						2,261	99					2,360	15
16	**TOTAL Health Care and Programs**	(184)			(4,143)		2,169	824					(1,334)	16
	C. General Administration													
17	Administrative					4,971		40,127	673				45,771	17
18	Directors Fees													18
19	Professional Services	(4,321)				(293,768)			15				(298,074)	19
20	Fees, Subscriptions & Promotions	(34,620)	570			6,519			19				(27,512)	20
21	Clerical & General Office Expenses	(1,509,472)	200			24,230	(8,298)	219,409	1,545				(1,272,386)	21
22	Employee Benefits & Payroll Taxes				(270)		(3,771)						(4,041)	22
23	Inservice Training & Education													23
24	Travel and Seminar					6,329			535				6,864	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice					2,261			478				2,739	26
27	Other (specify):*							37,237					37,237	27
28	**TOTAL General Administration**	(1,548,413)	770		(270)	(249,458)	(12,069)	296,773	3,265				(1,509,402)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,548,795)	770		(10,552)	(238,530)	770	311,530	8,788				(1,476,018)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number South Shore Nsg & Rehab Center **#** 0042119 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	49,615	290,388			31,595				275			371,873	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(560,176)	894,899			5,274			860	97			340,954	32
33	Real Estate Taxes					2,494							2,494	33
34	Rent-Facility & Grounds		(1,357,800)			11,811							(1,345,989)	34
35	Rent-Equipment & Vehicles					2,128			48				2,176	35
36	Other (specify):*		80,928										80,928	36
37	TOTAL Ownership	(510,561)	(91,585)			53,302			908	372			(547,564)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers				(11,775)				(17,358)	(825)			(29,958)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers				(11,775)				(17,358)	(825)			(29,958)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(2,059,356)	(90,815)		(22,327)	(185,228)	770	311,530	(7,662)	(453)			(2,053,540)	45

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				South Shore Properties, LLC		Building Co

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 1,357,800	South Shore Properties, LLC		$	$ (1,357,800)	1
2	V	32	Interest Income	147,060	South Shore Properties, LLC			(147,060)	2
3	V	20	Filing Fees		South Shore Properties, LLC		250	250	3
4	V	30	Depreciation		South Shore Properties, LLC		290,388	290,388	4
5	V	36	Amortization		South Shore Properties, LLC		80,928	80,928	5
6	V	32	Interest		South Shore Properties, LLC		1,041,959	1,041,959	6
7	V	21	Misc Admin Expense		South Shore Properties, LLC		200	200	7
8	V	20	Trust Fees		South Shore Properties, LLC		320	320	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,504,860			$ 1,414,045	$ * (90,815)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INSURANCE	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 86,120	$ 86,120	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INSURANCE	86,120	CCS EMPLOYEE BENEFIT GROUP	100.00%		(86,120)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 86,120			$ 86,120	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	DIETARY	$ 90	XCEL MEDICAL SUPPLY, LLC	100.00%	$ 81	$ (9)	15
16	V	02	FOOD		XCEL MEDICAL SUPPLY, LLC	100.00%			16
17	V	03	HOUSEKEEPING	59,572	XCEL MEDICAL SUPPLY, LLC	100.00%	53,666	(5,906)	17
18	V	04	LAUNDRY	1,478	XCEL MEDICAL SUPPLY, LLC	100.00%	1,332	(147)	18
19	V	06	REPAIRS & MAINTENANCE	779	XCEL MEDICAL SUPPLY, LLC	100.00%	701	(77)	19
20	V	10	NURSING	41,784	XCEL MEDICAL SUPPLY, LLC	100.00%	37,642	(4,143)	20
21	V	11	ACTIVITIES		XCEL MEDICAL SUPPLY, LLC	100.00%			21
22	V	20	DUES, FEES, SUBSCRIPTIONS & PROM		XCEL MEDICAL SUPPLY, LLC	100.00%			22
23	V	21	CLERICAL & GENERAL OFFICE		XCEL MEDICAL SUPPLY, LLC	100.00%			23
24	V	22	EMPLOYEE BENEFITS	2,728	XCEL MEDICAL SUPPLY, LLC	100.00%	2,458	(270)	24
25	V	39	ANCILLARY	118,768	XCEL MEDICAL SUPPLY, LLC	100.00%	106,993	(11,775)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 225,199			$ 202,872	$ * (22,327)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$	Care Centers, Inc.	100.00%	$ 482	$ 482	15
16	V	05	Utilities		Care Centers, Inc.	100.00%	3,033	3,033	16
17	V	06	Maintenance		Care Centers, Inc.	100.00%	7,413	7,413	17
18	V				Care Centers, Inc.	100.00%			18
19	V	17	Administration		Care Centers, Inc.	100.00%	4,971	4,971	19
20	V	19	Professional Fees	321,600	Care Centers, Inc.	100.00%	27,832	(293,768)	20
21	V	20	Dues and Subscriptions		Care Centers, Inc.	100.00%	6,519	6,519	21
22	V	21	Office & Clerical		Care Centers, Inc.	100.00%	24,230	24,230	22
23	V	24	Travel and Seminar		Care Centers, Inc.	100.00%	6,329	6,329	23
24	V	26	Insurance		Care Centers, Inc.	100.00%	2,261	2,261	24
25	V	30	Depreciation		Care Centers, Inc.	100.00%	31,595	31,595	25
26	V	32	Interest		Care Centers, Inc.	100.00%	5,274	5,274	26
27	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	2,494	2,494	27
28	V	34	Rent - Building		Care Centers, Inc.	100.00%	11,811	11,811	28
29	V	35	Rent - Equipment and Auto		Care Centers, Inc.	100.00%	2,128	2,128	29
30	V	25	Bus Reimbursement		Care Centers, Inc.	100.00%			30
31	V	02	Food		Care Centers, Inc.	100.00%			31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 321,600			$ 136,372	$ * (185,228)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance Salary	$ 2,338	Care Centers, Inc.	100.00%	$ 10,886	$ 8,548	15
16	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	2,122	2,122	16
17	V	10	Nursing Salary	14,031	Care Centers, Inc.	100.00%	14,031		17
18	V	10a	Rehab Salary	567	Care Centers, Inc.	100.00%	475	(92)	18
19	V								19
20	V								20
21	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	2,261	2,261	21
22	V	17	Administration Salary		Care Centers, Inc.	100.00%			22
23	V	21	Office Salary	8,298	Care Centers, Inc.	100.00%		(8,298)	23
24	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%			24
25	V	22	Employee Benefits	3,771	Care Centers, Inc.	100.00%		(3,771)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 29,005			$ 29,775	$ * 770	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		01	Dietary Salary	$	Care Centers, Inc.	100.00%	$ 5,497	$ 5,497	15
16	V									16
17	V		06	Maintenance Salary		Care Centers, Inc.	100.00%	6,686	6,686	17
18	V		07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	1,750	1,750	18
19	V									19
20	V		10a	Rehab Salary		Care Centers, Inc.	100.00%	725	725	20
21	V		15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	99	99	21
22	V									22
23	V		17	Administration Salary		Care Centers, Inc.	100.00%	40,127	40,127	23
24	V		21	Office Salary		Care Centers, Inc.	100.00%	219,409	219,409	24
25	V		27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	37,237	37,237	25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$ 311,530	$ * 311,530	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$ 16,341	Care Centers, Inc. - Health Systems Division	100.00%	$ 2,624	$ (13,717)	15
16	V	02	Food		Care Centers, Inc. - Health Systems Division	100.00%	8,597	8,597	16
17	V	06	Maintenance		Care Centers, Inc. - Health Systems Division	100.00%	92	92	17
18	V	17	Administration		Care Centers, Inc. - Health Systems Division	100.00%	673	673	18
19	V	19	Professional Fees		Care Centers, Inc. - Health Systems Division	100.00%	15	15	19
20	V	20	Dues & Subscriptions		Care Centers, Inc. - Health Systems Division	100.00%	19	19	20
21	V	21	Office & Clerical		Care Centers, Inc. - Health Systems Division	100.00%	1,545	1,545	21
22	V	24	Travel & Seminar		Care Centers, Inc. - Health Systems Division	100.00%	535	535	22
23	V	26	Insurance		Care Centers, Inc. - Health Systems Division	100.00%	478	478	23
24	V	30	Depreciaton	257	Care Centers, Inc. - Health Systems Division	100.00%	257		24
25	V	32	Interest		Care Centers, Inc. - Health Systems Division	100.00%	860	860	25
26	V	35	Rent - Equipment & Auto		Care Centers, Inc. - Health Systems Division	100.00%	48	48	26
27	V	39	Ancillary Enteral Supplies	36,628	Care Centers, Inc. - Health Systems Division	100.00%	19,270	(17,358)	27
28	V	01	Dietary - Salary		Care Centers, Inc. - Health Systems Division	100.00%	9,160	9,160	28
29	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc. - Health Systems Division	100.00%	1,391	1,391	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 53,226			$ 45,564	$ * (7,662)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation	$	Vent Lease, LLC.	100.00%	$ 275	$ 275	15
16	V	32	Interest		Vent Lease, LLC.	100.00%	97	97	16
17	V	39	Vent Reimbursement	825	Vent Lease, LLC.	100.00%		(825)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 825			$ 372	$ * (453)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sandy Bokor	Relative	Administrative		See Attached	1.00	2.00%	Mgmt Fees	$ 12,000	17-3	1
2	David Aronin	Owner	Administrative	0.83%	See Attached	2.01	3.58%	Alloc. Salary	6,421	17-7	2
3	Mark Steinberg	Relative	Administrative		See Attached	2.82	5.13%	Alloc. Salary	3,770	17-7	3
4	Eric Rothner	Relative	Administrative		See Attached	1.62	3.51%	Alloc. Salary	3,915	17-7	4
5	Adam Vales	Owner	Clerical	1.88%	See Attached	0.57	1.43%	Alloc. Salary	702	22-7	5
6	Gale Rothner	Relative	Administrative		See Attached	1.79	5.14%	Alloc. Salary	3,997	17-7	6
7	Kim Rudolph	Relative	Clerical		See Attached	0.68	1.94%	Alloc. Salary	1,215	22-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 32,020		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847)905-4000
Fax Number: (847)905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INSURAI	DIRECT ALLOCATION			$	$		$ 86,120	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 86,120	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: XCEL MEDICAL SUPPLY, LLC
Street Address: 2201 W. MAIN STREET
City / State / Zip Code: EVANSTON, IL 60202
Phone Number: (847)328-7600
Fax Number: (847)328-7615

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	DIETARY	Direct Allocation			$	$		$ 81	1
2	02	FOOD	Direct Allocation							2
3	03	HOUSEKEEPING	Direct Allocation						53,666	3
4	04	LAUNDRY	Direct Allocation						1,332	4
5	06	REPAIRS & MAINTENANCE	Direct Allocation						701	5
6	10	NURSING	Direct Allocation						37,642	6
7	11	ACTIVITIES	Direct Allocation							7
8	20	DUES, FEES, SUBSCRIPTIONS	Direct Allocation							8
9	21	CLERICAL & GENERAL OFFIC	Direct Allocation							9
10	22	EMPLOYEE BENEFITS	Direct Allocation						2,458	10
11	39	ANCILLARY	Direct Allocation						106,993	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 202,872	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,497,287	32	$ 9,406	$	76,725	$ 482	1
2	05	Utilities	Patient Days	1,497,287	32	59,188		76,725	3,033	2
3	06	Maintenance	Patient Days	1,497,287	32	144,661		76,725	7,413	3
4										4
5	17	Administration	Patient Days	1,497,287	32	97,000		76,725	4,971	5
6	19	Professional Fees	Patient Days	1,497,287	32	543,148		76,725	27,832	6
7	20	Dues and Subscriptions	Patient Days	1,497,287	32	127,217		76,725	6,519	7
8	21	Office & Clerical	Patient Days	1,497,287	32	472,845		76,725	24,230	8
9	24	Travel and Seminar	Patient Days	1,497,287	32	123,511		76,725	6,329	9
10	26	Insurance	Patient Days	1,497,287	32	44,126		76,725	2,261	10
11	30	Depreciation	Patient Days	1,497,287	32	616,575		76,725	31,595	11
12	32	Interest	Patient Days	1,497,287	32	102,930		76,725	5,274	12
13	33	Real Estate Taxes	Patient Days	1,497,287	32	48,662		76,725	2,494	13
14	34	Rent - Building	Patient Days	1,497,287	32	230,488		76,725	11,811	14
15	35	Rent - Equipment & Auto	Patient Days	1,497,287	32	41,530		76,725	2,128	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,661,288	$		$ 136,372	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	06	Maintenance Salary	Direct Cost			301,710	301,710		10,886	1
2	07	Emp. Ben. - Gen. Serv.	Direct Cost			46,639			2,122	2
3	10	Nursing Salary	Direct Cost			425,833	425,833		14,031	3
4	10a	Rehab Salary	Direct Cost			55,464	55,464		475	4
5										5
6										6
7	15	Emp. Ben. - Healthcare	Direct Cost			67,757			2,261	7
8	17	Administration Salary	Direct Cost			5,566	5,566			8
9	21	Office Salary	Direct Cost			419,879	419,879			9
10	27	Emp. Ben. - Gen. Admin.	Direct Cost			71,906				10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,394,755	$ 1,208,453		$ 29,775	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary Salary	Patient Days	1,497,287	32	107,276	107,276	76,725	5,497	1
2										2
3	06	Maintenance Salary	Patient Days	1,497,287	32	130,484	130,484	76,725	6,686	3
4	07	Emp. Ben. - Gen. Serv.	Patient Days	1,497,287	32	34,158		76,725	1,750	4
5										5
6	10a	Rehab Salary	Patient Days	1,497,287	32	14,139	14,139	76,725	725	6
7	15	Emp. Ben. - Healthcare	Patient Days	1,497,287	32	1,933		76,725	99	7
8					32					8
9	17	Administration Salary	Patient Days	1,497,287	32	783,083	783,083	76,725	40,127	9
10	21	Office Salary	Patient Days	1,497,287	32	4,281,771	4,281,771	76,725	219,409	10
11	27	Emp. Ben. - Gen. Admin.	Patient Days	1,497,287	32	726,674		76,725	37,237	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 6,079,517	$ 5,316,753		$ 311,530	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Billable Income	928,452		46,000		52,969	2,624	1
2	02	Food	Income			160,931			8,597	2
3	06	Maintenance	Billable Income	928,452		1,614		52,969	92	3
4	17	Administration	Billable Income	928,452		11,797		52,969	673	4
5	19	Professional Fees	Billable Income	928,452		262		52,969	15	5
6	20	Dues & Subscriptions	Billable Income	928,452		342		52,969	19	6
7	21	Office & Clerical	Billable Income	928,452		27,087		52,969	1,545	7
8	24	Travel & Seminar	Billable Income	928,452		9,381		52,969	535	8
9	26	Insurance	Billable Income	928,452		8,379		52,969	478	9
10	30	Depreciaton	Billable Income	928,452		4,499		52,969	257	10
11	32	Interest	Billable Income	928,452		15,077		52,969	860	11
12	35	Rent - Equipment & Auto	Billable Income	928,452		843		52,969	48	12
13	39	Ancillary Enteral Supplies	Income			327,517			19,270	13
14	01	Dietary - Salary	Billable Income	928,452		160,568	160,568	52,969	9,160	14
15	07	Emp. Ben. - Gen. Serv.	Billable Income	928,452		24,382		52,969	1,391	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 798,679	$ 160,568		$ 45,564	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Vent Lease, LLC
Street Address: 2201 W. Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	Depreciation	Direct Billing	593,410	29	$ 197,493	$	825	$ 275	1
2	32	Interest	Direct Billing	593,410	29	69,863		825	97	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 267,356	$		$ 372	25

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Business Partners LLC		X	Mortgage - Building Co.			$	$ 17,631,681			$ 550,066	1
2	Amcore		X	Mortgage - Building Co.							105,872	2
3	Corus Bank		X	Mortgage - Building Co.							370,806	3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Due from Affliates										15,215	6
7	Allocation from Vent Lease		X								97	7
8	See Supplemental Schedule										6,134	8
9	TOTAL Facility Related						$	$ 17,631,681			$ 1,048,190	9
	B. Non-Facility Related*											
10	Interest Income										(560,176)	10
11	Interest Income/Bldg Co.										(147,060)	11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (707,236)	14
15	TOTALS (line 9+line14)						$	$ 17,631,681			$ 340,954	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9	Allocation from Care Centers		X								6,134	9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										6,134	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number South Shore Nsg & Rehab Center **#** 0042119 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 344,335	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 338,438	2
3. Under or (over) accrual (line 2 minus line 1).		$ (5,897)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 352,741	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 346,844	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	324,625	8
	2001	332,159	9
	2002	334,103	10
	2003	327,938	11
	2004	335,944	12

2005 REAL ESTATE TAX - 2005 Expense $335,944 x 1.05=$352,700

Allocation from Care Center - $2,494

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME South Shore Nsg & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042119

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	21-30-200-001-0000	Long Term Care Property	$ 277,016.77	$ 277,016.77
2.	21-30-200-008-0000	Long Term Care Property	$ 51,673.10	$ 51,673.10
3.	21-30-200-002-0000	Long Term Care Property	$ 3,228.80	$ 3,228.80
4.	21-30-121-008-0000	Long Term Care Property	$ 1,515.93	$ 1,515.93
5.	21-30-121-009-0000	Long Term Care Property	$ 2,509.43	$ 2,509.43
6.	See Attached	Home Office Allocation	$ 48,662.44	$ 2,493.59
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 384,606.47	$ 338,437.62

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your real estate tax bills for calendar 2004.

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Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME South Shore Nsg & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042119

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2005.

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 Report Period Beginning: 01/01/05 Ending: 12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 96,000 B. General Construction Type: Exterior Brick Frame Steel & Masonry Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 4,380
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4,380
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	101,000	1994	$ 352,000	1
2	Alloc 2201 Main LLC		2002	18,022	2
3	TOTALS	101,000		$ 370,022	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1998	22,697		20	1,135	1,135	8,295	9
10	Various			1999	22,789		20	1,140	1,140	7,156	10
11	Various			2000	41,526		20	2,076	2,076	12,035	11
12	Various			2001	43,128		20	2,158	2,158	9,497	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
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36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
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61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		11,725,819	288,253		335,240	46,987	2,503,393	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		70,729	2,899		2,899		8,735	68
69	Financial Statement Depreciation			60,952			(60,952)		69
70	TOTAL (lines 4 thru 69)		$ 11,926,688	$ 352,104		$ 344,648	$ (7,456)	$ 2,549,111	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 11,926,688	$ 352,104		$ 344,648	$ (7,456)	$ 2,549,111	1
2	Motor	2002	582		20	58	58	223	2
3	Water Treatment	2002	1,692		20	141	141	541	3
4	Cable Lines	2002	518		20	52	52	190	4
5	Cable Lines	2002	1,025		20	103	103	376	5
6	Chiller	2002	890		20	89	89	326	6
7	Dining Room Renov	2002	17,195		20	1,720	1,720	6,018	7
8	Leasehold Imrprovement	2002	689		20	69	69	224	8
9	Leasehold Improvements	2002	954		20	95	95	302	9
10	Leasehold Improvements	2002	1,910		20	191	191	605	10
11	Pump Motor	2002	1,100		20	110	110	339	11
12	Water Treatment System	2002	1,004		20	100	100	343	12
13	Window Treatments	2002	650		20	65	65	233	13
14	Locks	2002	508		20	51	51	203	14
15	Chiller	2002	8,760		20	876	876	2,847	15
16	Carpeting	2003	527		20	75	75	226	16
17	Lighting And Ballists	2003	548		20	27	27	82	17
18	Covers	2003	750		20	75	75	219	18
19	Applied Sealcoating	2003	1,145		20	115	115	286	19
20	Carpeting For 14 Rooms	2003	24,080		20	3,440	3,440	8,313	20
21	Generator Service	2003	1,150		20	58	58	129	21
22	Door Keypads	2003	1,288		20	64	64	145	22
23	Front And Back Door Keypads	2003	958		20	48	48	108	23
24	Corner Guards	2003	1,788		20	179	179	387	24
25	Elevator Repair	2003	1,300		20	65	65	141	25
26	Paint	2003	1,652		20	165	165	358	26
27	Pave Lot	2003	1,376		20	138	138	298	27
28	Elevator Repair	2003	813		20	41	41	88	28
29	Wrist Band Trnsm.	2003	1,010		20	202	202	438	29
30	Sprinkler System	2003	581		20	58	58	140	30
31	Repair Dietary Door	2004	1,100		20	220	220	403	31
32	Pop Up Spray Heads	2004	654		20	65	65	120	32
33	Damper Motor	2004	1,635		20	327	327	572	33
34	TOTAL (lines 1 thru 33)		$ 12,006,520	$ 352,104		$ 353,730	$ 1,626	$ 2,574,334	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 12,006,520	$ 352,104		$ 353,730	$ 1,626	$ 2,574,334	1
2	New Damper	2004	1,763		20	353	353	617	2
3	Fire Alarm Repair	2004	1,009		20	202	202	353	3
4	Fire Damper Repair	2004	1,631		20	326	326	571	4
5	Door Delay Lock	2004	2,247		20	225	225	375	5
6	Nustep	2004	3,530		20	353	353	559	6
7	Door Opener	2004	2,040		20	408	408	646	7
8	Wiring	2004	695		20	70	70	104	8
9	T-Stat	2004	1,050		20	105	105	158	9
10	Paint Job	2004	3,550		20	355	355	473	10
11	Lawn Cleanup	2004	7,000		20	700	700	933	11
12	Carpet Strips	2004	1,359		20	136	136	181	12
13	Repair Booster Heater	2004	1,052		20	105	105	140	13
14	Generator Service	2004	601		20	120	120	160	14
15	New Camera System	2004	7,002		20	700	700	875	15
16	Replace Spray Heads	2004	520		20	52	52	65	16
17	Security Power Supply	2004	540		20	108	108	135	17
18	Generator Maint	2004	1,293		20	259	259	323	18
19	Wrist Band Transm	2004	999		20	200	200	250	19
20	4 Mag Locks	2004	3,692		20	369	369	431	20
21	Lab & Wiring 2Nd Fl	2004	595		20	119	119	139	21
22	Lab & Wiring Sys Buzzing	2004	760		20	152	152	177	22
23	Elevator Hatch Doors	2004	2,651		20	530	530	1,061	23
24	Pump Drain	2004	1,667		20	167	167	194	24
25	Floor Treatment	2004	810		20	41	41	57	25
26	Paint	2004	2,330		20	117	117	214	26
27	Repair Cut Piping	2005	4,333		20	397	397	397	27
28	Door Repairs	2005	2,840		20	473	473	473	28
29	Boiler Repair	2005	2,781		20	417	417	417	29
30	2 Door Locks	2005	3,691		20	246	246	246	30
31	New Compressor	2005	6,341		20	740	740	740	31
32	New Compressor	2005	6,342		20	740	740	740	32
33	New Compressor	2005	6,341		20	740	740	740	33
34	TOTAL (lines 1 thru 33)		$ 12,089,575	$ 352,104		$ 363,755	$ 11,651	$ 2,587,278	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 12,089,575	$ 352,104		$ 363,755	$ 11,651	$ 2,587,278	1
2	New Compressor	2005	6,341		20	423	423	423	2
3	New Compressor	2005	6,341		20	317	317	317	3
4	Boiler Repair	2005	2,703		20	135	135	135	4
5	New Compressor	2005	6,341		20	211	211	211	5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,111,301	$ 352,104		$ 364,841	$ 12,737	$ 2,588,364	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 12,111,301	$ 352,104		$ 364,841	$ 12,737	$ 2,588,364	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,111,301	$ 352,104		$ 364,841	$ 12,737	$ 2,588,364	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 12,111,301	$ 352,104		$ 364,841	$ 12,737	$ 2,588,364	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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16									16
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,111,301	$ 352,104		$ 364,841	$ 12,737	$ 2,588,364	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 12,111,301	$ 352,104		$ 364,841	$ 12,737	$ 2,588,364	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,111,301	$ 352,104		$ 364,841	$ 12,737	$ 2,588,364	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 12,111,301	$ 352,104		$ 364,841	$ 12,737	$ 2,588,364	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,111,301	$ 352,104		$ 364,841	$ 12,737	$ 2,588,364	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 12,111,301	$ 352,104		$ 364,841	$ 12,737	$ 2,588,364	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,111,301	$ 352,104		$ 364,841	$ 12,737	$ 2,588,364	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 12,111,301	$ 352,104		$ 364,841	$ 12,737	$ 2,588,364	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,111,301	$ 352,104		$ 364,841	$ 12,737	$ 2,588,364	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		$ 12,111,301	$ 352,104		$ 364,841	$ 12,737	$ 2,588,364	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,111,301	$ 352,104		$ 364,841	$ 12,737	$ 2,588,364	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	240		1998	1998	$ 11,715,725	$ 288,253	35	$ 334,735	$ 46,482	$ 2,499,858	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Fence - South Shore Building Company			1998	10,094		20	505	505	3,535	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
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36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
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62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 11,725,819	$ 288,253		$ 335,240	$ 46,987	$ 2,503,393	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	2201 Main LLC		2002	2002	$ 24,835	$ 637	40	$ 637	$	$ 2,096	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocation - 2201 Main LLC			2002	20,516	1,026	20	1,026		3,590	9
10	Allocation - 2201 Main LLC			2003	24,177	1,209	20	1,209		3,022	10
11	Allocation - 2201 Main LLC			2006	1,201	27	20	27		27	11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
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60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 70,729	$ 2,899		$ 2,899	$	$ 8,735	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,318,795	$ 28,071	$ 63,116	$ 35,045	10	$ 1,143,835	71
72	Current Year Purchases	35,919	502	1,890	1,388	10	1,890	72
73	Fully Depreciated Assets	20,733				10	20,733	73
74								74
75	TOTALS	$ 1,375,447	$ 28,573	$ 65,006	$ 36,433		$ 1,166,458	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		2002 CHEVY MALIBU	2005	$ 5,332	$ 355	$ 800	$ 445	5	$ 800	76
77		Allocation from Care Centers	2005	34,803	2,534	2,534		5	26,203	77
78										78
79										79
80	TOTALS			$ 40,135	$ 2,889	$ 3,334	$ 445		$ 27,003	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 13,896,905	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 383,566	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 433,181	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 49,615	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,781,825	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 Report Period Beginning: 01/01/05 Ending: 12/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocation from Care Centers				11,811			5
6								6
7	TOTAL				$ 11,811 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 8,107 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	Chevy Malibu	$ 328.73	$ 2,959	17
18					18
19					19
20					20
21	TOTAL		$ 328.73	$ 2,959	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 330,614	$		$ 330,614	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			12,616			12,616	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			432,251			432,251	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				232,887		232,887	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental					5,372	266,634		272,006	13
14	TOTAL			$		$ 780,853	$ 499,521		$ 1,280,374	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 Report Period Beginning: 01/01/05 Ending: 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/05 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$ 303,308	1
2	Cash-Patient Deposits	116,519	116,519	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,355,616	1,355,616	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	286,426	286,426	6
7	Other Prepaid Expenses	827	827	7
8	Accounts Receivable (owners or related parties)	8,922,848	12,835,910	8
9	Other(specify): See Attached Schedule	183,967	183,967	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 10,866,203	$ 15,082,573	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		352,000	13
14	Buildings, at Historical Cost		10,177,369	14
15	Leasehold Improvements, at Historical Cost	225,911	688,530	15
16	Equipment, at Historical Cost	384,697	2,833,389	16
17	Accumulated Depreciation (book methods)	(321,602)	(5,000,148)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule		182,594	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 289,006	$ 9,233,734	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 11,155,209	$ 24,316,307	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,018,835	$ 1,018,836	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	109,752	109,752	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	371,548	371,548	30
31	Accrued Taxes Payable (excluding real estate taxes)	29,965	29,965	31
32	Accrued Real Estate Taxes(Sch.IX-B)	352,741	352,741	32
33	Accrued Interest Payable		97,929	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	44,650	44,650	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,927,491	$ 2,025,421	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		17,631,681	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 17,631,681	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,927,491	$ 19,657,102	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 9,227,718	$ 4,659,205	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 11,155,209	$ 24,316,307	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number South Shore Nsg & Rehab Center **#** 0042119 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 8,660,434	1
2	Restatements (describe):		2
3	Vacation Accrual Journal Entry	(20,584)	3
4	Medicare Settlement - Revenue Adjustments	93,624	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 8,733,474	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	735,244	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(241,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 494,244	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 9,227,718	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 11,814,026	1
2	Discounts and Allowances for all Levels	(3,159,218)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,654,808	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,130,996	6
7	Oxygen	37,548	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,168,544	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	252,050	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	91,261	19
20	Radiology and X-Ray	11,270	20
21	Other Medical Services	81,411	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 435,992	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	560,176	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 560,176	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	326	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 326	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,819,846	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,911,291	31
32	Health Care	3,707,402	32
33	General Administration	3,277,408	33
	B. Capital Expense		
34	Ownership	1,776,727	34
	C. Ancillary Expense		
35	Special Cost Centers	1,280,374	35
36	Provider Participation Fee	131,400	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,084,602	40
41	**Income before Income Taxes (line 30 minus line 40)****	735,244	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 735,244	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Not Complete **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,813	1,834	$ 56,896	$ 31.02	1
2	Assistant Director of Nursing	3,592	4,152	117,361	28.27	2
3	Registered Nurses	11,960	13,654	319,083	23.37	3
4	Licensed Practical Nurses	51,098	55,667	1,154,540	20.74	4
5	CNAs & Orderlies	124,898	132,486	1,267,205	9.56	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,341	9,425	115,771	12.28	8
9	Activity Director	805	1,006	13,317	13.24	9
10	Activity Assistants	17,057	18,720	164,507	8.79	10
11	Social Service Workers	14,674	16,034	197,817	12.34	11
12	Dietician	1,988	2,018	29,703	14.72	12
13	Food Service Supervisor	1,920	2,117	36,304	17.15	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,387	5,936	61,514	10.36	15
16	Dishwashers	27,493	29,439	238,757	8.11	16
17	Maintenance Workers	6,704	6,964	84,859	12.19	17
18	Housekeepers	27,879	30,064	239,058	7.95	18
19	Laundry	13,500	14,786	125,523	8.49	19
20	Administrator	1,926	2,225	63,332	28.46	20
21	Assistant Administrator	1,228	1,423	31,389	22.06	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,496	7,831	87,237	11.14	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,027	2,200	21,983	9.99	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	1,826	2,036	18,369	9.02	33
34	TOTAL (lines 1 - 33)	333,612	360,017	$ 4,444,525 *	$ 12.35	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	349	$ 24,145	01-03	35
36	Medical Director	Monthly	27,000	09-03	36
37	Medical Records Consultant	Monthly	4,472	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,528	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	52	2,536	11-03	44
45	Social Service Consultant	22	1,202	12-03	45
46	Other(specify)				46
47	Psycho-Social Consultant	3	150	12-03	47
48	Care Centers - See Attached		14,598	Various	48
49	TOTAL (lines 35 - 48)	426	$ 76,631		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	93	$ 4,880	10-03	50
51	Licensed Practical Nurses	3,933	128,429	10-03	51
52	Certified Nurse Assistants/Aides	18	339	10-03	52
53	TOTAL (lines 50 - 52)	4,043	$ 133,648		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
David Vardi	Administrator	0	$ 63,332
Carolyn Sanders	Assistant Administrator	0	31,389
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 94,721

B. Administrative - Other

Description	Amount
	$
Management Fees-Sandy Bokor	12,000
Management Fees - Alan Abrams	12,000
Management Fees - Ronald Abrams	12,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 36,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 33,000
BDO Seidman	Audit Fee	1,075
SMS	Consulting	7,798
Pesonnel Planners	Unemployment Consult	2,538
HFG	Audit Fee	1,172
Ehealth Data	MDS Software	1,770
Care Centers Inc.	Home Office Expense	321,600
Prospect Resources	Consulting	600
See Attached	Legal	7,826
ADP	Data Processing	13,839
Illinois Health Care Assn	Other Professional Fees	1,800
See Supplemetal Schedule		9,365
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 402,383

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 107,711
Unemployment Compensation Insurance	88,205
FICA Taxes	322,485
Employee Health Insurance	128,060
Employee Meals	8,935
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	2,728
Pension Expense	15,620
Union Pension	17,113
Chicago Head Tax	10,083
Other Employee Welfare	3,958
Holiday Expense	1,623
TOTAL (agree to Schedule V, line 22, col.8)	$ 706,522

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,900
Health Care Worker Background Check	
(Indicate # of checks performed)	4,054
Licenses & Fees	9,154
Advertising & Promotion	32,950
Dues & Subscriptions	15,592
Classified Advertising	35,028
Allocation from Care Centers	6,538
Less: Public Relations Expense	( )
Non-allowable advertising	(32,950)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 73,266

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	708
Allocation from Care Centers	6,864
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,572

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number South Shore Nsg & Rehab Center # 0042119 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC - $10,163.40**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,495** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **131,400**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **8,935** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.